Medical Supplies and Equipment

General Payment Policies

- The Department pays providers for certain medical supplies and equipment (MSE) dispensed from their offices when these items are considered prosthetics and are used for a client's permanent condition (see the list beginning on page K.2).

- Most MSE used to treat a client's temporary or acute condition are considered incidental to a provider's professional services and are bundled in the office visit payment (see list beginning on page K.2). The Department pays providers separately for only those MSE listed beginning on page K.5.

- The Department does not pay providers separately for surgical trays, as these are bundled within the appropriate surgical procedure. The fees for these procedures include the cost of the surgical trays.

- Procedure codes for MSE that do not have a maximum allowable fee and cost less than $50.00 are paid at acquisition cost. A manufacturer's invoice must be maintained in the client's records for MSE under $50.00 and made available to the Department upon request. **DO NOT send in an invoice with a claim** for MSE under $50.00 unless requested by the Department.

- Procedure codes for MSE that do not have a maximum allowable fee and cost $50.00 or more are paid at acquisition cost. **A copy of the manufacturer's invoice must be attached** to the claim for MSE costing $50.00 or more.

Note: Refer to the *Important Contacts* section for information on prior authorization.

Supplies Included in an Office Call (Bundled Supplies)

Items with an asterisk (*) in the following list are considered prosthetics when used for a client's permanent condition. The Department pays providers for these supplies when they are provided in the office for permanent conditions **only**. They are not considered prosthetics if the condition is acute or temporary. Providers must indicate "prosthetic for permanent condition" in the *Comments* section of the claim form.

For example, if a patient has an indwelling Foley catheter for permanent incontinence and a problem develops for which the physician is required to replace the catheter, it is considered a prosthetic and is paid separately. The Foley catheter used to obtain a urine specimen, used after surgery, or used to treat an acute obstruction is not paid separately because it is treating a temporary problem.

HCPCS Code	Brief Description
99070	Special supplies
A4206	Syringe with needle, sterile 1cc
A4207	Syringe with needle, sterile 2cc
A4208	Syringe with needle, sterile 3cc
A4209	Syringe with needle, sterile 5cc
A4211	Supplies for self-administered injections
A4212	Huber-type needle, each
A4213	Syringe, sterile, 20 CC or greater
A4215	Needles only, sterile, any size
A4220	Refill kit for implantable infusion pump
A4244	Alcohol or peroxide, per pint
A4245	Alcohol wipes, per box
A4246	Betadine or phisohex solution, per pint
A4247	Betadine or iodine swabs/wipes, per box
A4252	Blood ketone test or strip
A4253	Blood glucose test, per 50 strips
A4256	Normal, low and high cal solution/chips
A4258	Spring-powered device for lancet, each
A4259	Lancets, per box of 100
A4262	Temporary lacrimal duct implant, each
A4263	Permanent lacrimal duct implant, each
A4265	Paraffin, per pound
A4270	Disposable endoscope sheath, each
A4300	Implantable access partial/catheter
A4301	Implantable access total system
A4305	Disposable drug delivery system, flow rate 50 ML or more per hour
A4306	Disposable drug delivery system, flow rate 5 ML or less per hour
A4310	Insertion tray w/o drainage bag
A4311	Insertion tray without drainage bag

HCPCS Code	Brief Description
A4312	Insertion tray without drainage bag
A4313	Insertion tray without drainage bag
A4314	Insertion tray with drainage bag
A4315	Insertion tray with drainage bag
A4316	Insertion tray with drainage bag
A4320	Irrigation tray for bladder
A4330	Perianal fecal collection pouch
A4335*	Incontinence supply; miscellaneous
A4338*	Indwelling catheter; Foley type
A4340*	Indwelling catheter; Spec type
A4344*	Indwelling catheter; Foley type
A4346*	Indwelling catheter; Foley type
A4351	Intermittent urinary catheter
A4352	Intermittent urinary catheter
A4353	Catheter insert tray with cath/tube/bag
A4354	Insertion tray with drainage bag
A4355	Irrigation tubing set
A4356*	External urethral clamp device
A4357*	Bedside drainage bag, day or night
A4358*	Urinary leg bag; vinyl
A4361*	Ostomy faceplate
A4362*	Skin barrier; solid, 4 x 4
A4364*	Adhesive for ostomy or catheter
A4367*	Ostomy belt
A4368*	Ostomy filter, each
A4397	Irrigation supply; sleeve
A4398*	Irrigation supply; bags
A4399*	Irrigation supply; cone/catheter
A4400*	Ostomy irrigation set
A4402	Lubricant
A4404*	Ostomy rings
A4421*	Ostomy supply; miscellaneous
A4455	Adhesive remover or solvent
A4461	Surgical dressing holder, nonreusable, each
A4463	Surgical dressing holder, reusable, each
A4465	Non-elastic binder for extremity
A4470	Gravlee jet washer
A4480	Vabra aspirator
A4550	Surgical tray
A4556	Electrodes (e.g., apnea monitor)
A4557	Lead wires (e.g., apnea monitor)
A4558	Conductive paste or gel
A4649	Surgical supply; miscellaneous

HCPCS Code	Brief Description
A5051*	Ostomy pouch, closed; with barrier
A5052*	Ostomy pouch, closed; without barrier
A5053*	Ostomy pouch, closed; use on faceplate
A5054*	Ostomy pouch, closed; use on barrier
A5055*	Stoma cap
A5061*	Ostomy pouch, drainable; with barrier
A5062*	Ostomy pouch, drainable; without barrier
A5063*	Ostomy pouch, drainable; use on barrier
A5071*	Pouch, urinary; with barrier
A5072*	Pouch, urinary; without barrier
A5073*	Pouch, urinary; use on barrier
A5081*	Continent device ; plug
A5082*	Continent device ; catheter
A5083*	Stoma absorptive cover
A5093*	Ostomy accessory; convex insert
A5102*	Bedside drainage bottle
A5105*	Urinary supensory; with leg bag
A5112*	Urinary leg bag; latex
A5113*	Leg strap; latex, per set
A5114*	Leg strap; foam or fabric
A5120	Skin barrier, wipe or swab
A5121*	Skin barrier; solid, 6 x 6
A5122*	Skin barrier; solid, 8 x 8
A5126*	Adhesive; disc or foam pad
A5131*	Appliance cleaner
A6021	Collagen dressing <=16 sq in
A6022	Collagen drsg>6<=48 sq in
A6023	Collagen dressing >48 sq in
A6024	Collagen dsg wound filler
A6025	Silicone gel sheet, each
A6154	Wound pouch, each
A6231	Hydrogel dsg <=16 sq in
A6232	Hydrogel dsg>16<=48 sq in
A6233	Hydrogel dressing >48 sq in
A6413	Adhesive bandage first-aid

Supplies Paid Separately When Dispensed from a Provider's Office/Clinic

Miscellaneous Supplies

HCPCS Code	Brief Description
A4561	Pessary rubber, any type
A4562	Pessary, nonrubber, any type
A4565	Slings
A4570	Splint
L8695	External recharge sys extern, **requires PA**

Casting Materials

Bill the appropriate HCPCS code (Q4001-Q4051) for fiberglass and plaster casting materials. Do not bill for the use of a cast room. Use of a cast room is considered part of a provider's practice expense.

Metered Dose Inhalers and Accessories

HCPCS Code	Brief Description
A4614	Peak flow meter
A4627	Spacer bag, or reservoir, with/without mask (for use with metered does inhaler)

Inhalation Solutions

Refer to the fee schedule for those specific codes for inhalation solutions that are paid separately.

Radiopharmaceutical Diagnostic Imaging Agents

Refer to the fee schedule for those specific codes for imaging agents that are paid separately.

Miscellaneous Prosthetics & Orthotics

HCPCS Code	Brief Description
L0120	Collar-philadelphia child
L0220	Thoracic, rib belt, custom fabricated
L1810	Knee brace hinged
L1820	Action neoprene brace, knee
L1830	Knee immobilizer 24" universal
L3650	Shoulder abduction pillow
L3807	WHFO, extension assist, with inflatable palmer air support, with or without thumb extension
L3908	Wrist comfort form all sizes
L8000	Post mastectomy implants bra
L8010	Breast binder
L8600	Breast implants

Note: See page K.7 for Misc. prosthetics and orthotics that only Podiatrists and Orthopedic Surgeons can bill for.

Urinary Tract Implants

See important policy limitations for urinary tract implants in Section F.

HCPCS Code	Brief Description
L8603	Collagen implant, urinary tract, per 2.5 ml syringe
L8606	Synthetic implant, urinary tract, per 1 ml syringe

Note: The Department does not pay providers for L8603 and L8606 if the implants are done outside the physician's office.

The Department covers the first five (5) implants only, using a combination of L8603 and/or L8606, per client. Each 2.5 ml syringe of L8603 or each 1 ml syringe of L8606 is one implant.

Podiatry and Orthopedic Surgeons

The following codes are payable only to podiatrists and orthopedic surgeons:

HCPCS Code	Brief Description
A5500	Diab shoe for density insert
A5501	Diabetic custom molded shoe
A5503	Diabetic shoe w/roller/rocker
A5504	Diabetic shoe with wedge
A5505	Diab shoe w/metatarsal bar
A5506	Diabetic shoe w/offset heal
A5507	Modification diabetic shoe (requires PA)
A5512	Multi den insert direct form
A5513	Multi den insert custom mold
L1902	Boot-walkabout med/large
L1906	Canvas ankle brace
L3000	Ft insert ucb berkeley shell. **EPA required.**
L3030	Foot arch support remov prem. **EPA required.**
L3100	Hallus-valgus nght dynamic s
L3140	Abduction rotation bar shoe
L3150	Abduct rotation bar w/o shoe
L3170	Foot plastic foot stabilizer. **PA required.**
L3215	Orthopedic ftwear ladies oxf. **EPA required.**
L3219	Orthopedic mens shoes oxford. **EPA required.**
L3230	Custom shoes depth inlay.
L3310	Shoe lift elev heel/sole neo. **EPA required.**
L3320	Shoe lift elev heel/sole cor. **EPA required.**

Podiatry and Orthopedic Surgeons (cont.)

HCPCS Code	Brief Description
L3334	Shoe lifts elevation heel /i. **EPA required.**
L3340	Shoe wedge sach. **PA required.**
L3350	Shoe heel wedge. **PA required.**
L3360	Shoe sole wedge outside sole. **PA required.**
L3400	Shoe metatarsal bar wedge ro. **PA required.**
L3410	Shoe metatarsal bar between. **PA required.**
L3420	Full sole/heel wedge between. **PA required.**
L3430	Shoe heel count plast reinfor
L4350	Air support – purple med/large
L4360	Walker, pneumatic s-m-l **PA required.**
L4380	Aircast infrapatellar band
L4386	Diabetic walker **PA required.**

Injectable Drug Codes

What Drugs *Are* Covered? [Refer to WAC 388-530-2000 (1)]

The Department covers outpatient drugs, including over-the-counter drugs listed on the Department's Covered Over-the-Counter Drug list, as defined in WAC 388-530-1050, subject to the limitations and requirements in this section, when:

- The drug is approved by the Food and Drug Administration (FDA);
- The drug is for a medically accepted indication as defined in WAC 388-530-1050;
- The drug is not excluded from coverage (see ―WAC 388-530-2000 Covered – Outpatient drugs, devices, and drug related supplies); and
- The manufacturer has a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS). Exceptions to the drug rebate requirement are described in WAC 388-530-7500 which describes the drug rebate program.

For more information go to:
http://hrsa.dshs.wa.gov/download/Billing_Instructions/Prescription_Drug/Prescription_Drug_Program_BI.pdf

The Department's fees for injectable drug codes are the maximum allowances used to pay covered drugs and biologicals administered in a provider's office only.

The Department follows Medicare's drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, the Department prices the drug at 84% of the Average Wholesale Price (AWP). The Department updates the rates each time Medicare's rate is updated, up to once per quarter. Unlike Medicare, the Department effective dates are based on dates of service, not the date the claim is received. For HCPCS codes where Medicare does not establish a rate, the Department determines the maximum allowances for covered drugs using the following methodology:

1. For a single-source drug or biological, the AWP equals the AWP of the single product.
2. For a multi-source drug or biological, the AWP is equal to the median AWP of all of the generic forms of the drug or biological, or the lowest brand-name product AWP, whichever is less. A "brand-name" product is defined as a product that is marketed under a labeled name that is other than the generic chemical name for the drug or biological.
3. After determining the AWP according to #1 and #2 above, the Department multiplies the amount by 0.84 to arrive at the fee schedule maximum allowance.

When billing for injectable drugs and biologicals, providers must use the description of the procedure code to determine the units, and include the correct number of units on the claim form to be paid the appropriate amount. For drugs priced at "acquisition cost," providers must:

- Include a copy of the manufacturer's invoice for each line item in which **billed charges** exceed $1,100.00; or

- Retain a copy of the manufacturer's invoice in the client's record for each line item in which **billed charges** are equal to or less than $1,100.00.

Do not bill using unclassified or unspecified drug codes unless there is no specific code for the drug being administered. The National Drug Code (NDC) and dosage given to the client must be included with the unclassified or unspecified drug code for coverage and payment consideration.

HCPCS codes J8499 and J8999 for oral prescription drugs are not covered.

Injectable drugs can be injected subcutaneously, intramuscularly, or intravenously. You must indicate that the injectable drugs came from the provider's office supply. The name, strength, and dosage of the drug must be documented and retained in the client's record.

Chemotherapy Drug (J9000-J9999)

- Bill number of units used based on the description of the drug code. For example, if 250 mg of Cisplatin (J9062) is given to the client, the correct number of units is five (5).

- The Department follows Medicare's drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, the Department continues to price the drug at 84% of the Average Wholesale Price (AWP).

All Other Drugs

- Bill number of units used based on the description of the drug code.

- Claims with HCPCS code J3490 must:

  ✓ Include the NDC in the correct format depending on the claim media and the amount of the drug administered to the client in the claim notes field; and
  ✓ Must be billed with one unit only.

- The Department follows Medicare's drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, the Department continues to price the drug at 84% of the Average Wholesale Price (AWP).

Prior Authorization

Drugs requiring written/fax prior authorization are noted in the fee schedule with a "PA" next to them. For information on how to request prior authorization, refer to Section I.

Rounding of Units

The following guidelines should be used to round the dosage given to the client to the appropriate number of units for billing purposes:

I. Single-Dose Vials:

For single-dose vials, bill the total amount of the drug contained in the vial(s), including partial vials. Based on the unit definition for the HCPCS code, the Department pays providers for the total number of units contained in the vial. **For example:**

If a total of 150 mg of Etoposide is required for the therapy and two 100 mg single dose vials are used to obtain the total dosage, the total of the two 100 mg vials is paid. In this case, the drug is billed using HCPCS code J9181 (Etoposide, 10 mg). If the Department's maximum allowable fee is $4.38 per 10 mg unit, the total allowable is $87.60 (200 mg divided by 10 = 20 units x $4.38).

II. Billing for Multi-Dose Vials:

For multi-dose vials, bill **only** the amount of the drug administered to the client. Based on the unit definition (rounded up to the nearest whole unit) of the HCPCS code, the Department pays providers for only the amount of drug administered to the client. **For example:**

If a total of 750 mg of Cytarabine is required for the therapy and is taken from a 2,000 mg multi-dose vial, only the 750 mg administered to the client is paid. In this case, the drug is billed using HCPCS code J9110 (Cytarabine, 500 mg). If the Department's maximum allowable fee is $23.75 per 500 mg unit, the total allowable is $47.50 [750 mg divided by 500 = 2 (1.5 rounded) units x $23.75].

Synagis (CPT® code 90378)

See Section C for information on Synagis.

Unlisted Drugs (J3490 and J9999)

When it is necessary to bill the Department for a drug using an unlisted drug code, providers must report the National Drug Code (NDC) of the drug administered to the client. The Department uses the NDC when unlisted drug codes are billed to appropriately price the claim.

To be reimbursed:

- Claims *must* include:
  - ✓ The dosage (amount) of the drug administered to the client;
  - ✓ The 11-digit NDC of the office-administered drug; and
  - ✓ One unit of service;
- The drug must be approved by the Food and Drug Administration (FDA);
- The drug must be for a medically accepted indication as defined in WAC 388-530-1050 (see —WAC 388-530-2000 Covered – Outpatient drugs, devices, and drug related supplies); and
- The drug must not be excluded from coverage.
- For claims billed using a paper CMS-1500 Claim Form, list the required information in field 19 of the claim form.
- For claims billed using an electronic CMS-1500 Claim Form, list the required information in the *Comments* section of the claim form.
- For claims billed using an electronic 837P claim form, list the required NDC information in DRUG IDENTIFICATION Loop 2410, LIN02, and LIN03. List the dosage given to the client in the *Comments* section of the claim form.

See Section C of these billing instructions for more detailed information on NDC billing.

> **Note**: If there is an assigned HCPCS code for the administered drug, providers **must bill** the Department using the appropriate HCPCS code. ***DO NOT*** bill using an unlisted drug code for a drug that has an assigned HCPCS code. The Department will recoup payment for drugs paid using an unlisted drug code if an assigned HCPCS code exists for the administered drug.

The list of all injectable drug codes and maximum allowable fees are listed in the fee schedule. The fee schedule may be accessed on the Department's web site at: http://hrsa.dshs.wa.gov/RBRVS/index.html

Invoice Requirements

A copy of the manufacturer's invoice showing the **actual acquisition cost** of the drug must be attached to the claim ***ONLY*** when billed charges exceed $1,100.00 per line item. If billed charges are less than $1,100.00 per line item, ***DO NOT*** attach the invoice or any other paperwork to your claim. If needed, the Department will request any other necessary documentation after receipt of the claim.

This requirement applies to **all drugs** administered in the provider's office, including those drugs with an assigned CPT or HCPCS code, and those drugs billed using either unlisted drug code J3490 or J9999.

A copy of any manufacturer's invoices for all drugs (regardless of billed charges) must be maintained in the client's record and made available to the Department upon request.